DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

	(1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 155319	(X2) MI A. BUII B. WIN	LDING	INSTRUCTION	(X3) DATE: COMPL 03/16/2	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF CLINTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
(PSR) to the Inves IN00084624 comp Complaint IN0008	84624- not corrected. ed to the allegations are 1 F226 6/11 000212 155319 285040 /TC N	F00	00	Preparation and/or execution this plan of corrective, in general or this corrective action in particular, does not constitute admission or agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepare and/or executed in compliance with state and federal laws.	eral, and is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G9ZH12

Facility ID:

000212

If continuation sheet

TITLE

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE COMP 03/16/2	LETED
		100019	B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1TH ST		
	OF CLINTON THE		CLINTO	ON, IN47842		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	ION D BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
		accordance with 410 IAC				
	16.2.	ompleted on March 17,				

	FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLI	ETED
1553	19 B.	B. WING			03/16/20	J11
NAME OF PROVIDER OR SUPPLIER WATERS OF CLINTON THE			375 S 1	.DDRESS, CITY, STATE, ZIP CODE 1TH ST DN, IN47842		
(X4) ID SUMMARY STATEME PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	Γ BE PERCEDED BY FULL	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F0225 SS=D Based on record review facility failed to ensure violations of physical a misappropriation of res 2 of 4 residents with all physical abuse and/or n their property (i.e. miss sample of 12; in that 1 were not immediately rofficials (ISDH) and/or potential abuse was no investigations as staff were allowed to work a were voiced by staff. (Indicated Resident B hamissing on 3/12/11 and facility staff of the mis her belongings on 3/12/1 indicated the resident standard the re	all alleged buse and/or ident property for egations of nisappropriation of sing property) in a) the allegations eported to other 2.) further t prevented during with allegations fter the allegations Residents A and B) roperty Report 1 at 1 p.m., ad identified \$12 had notified the sing money from 11. The report sated the money drawer between he report indicated blaced by the	F022	25	F 225 Investigate/Report Allegations/Individuals It is the intent of this facility to ensure all alleged violations of physical abuse and/or misappropriation of resident property are immediately report to ISDH; and further potential abuse is prevented until investigation is completed by immediate suspension of persorallegation is against. 1. CORRECTIVE ACTION:a. The allegation of Resident B's miss money was reported to ISDH of 03/16/11. b. The allegation of taping Resident A's release se belt with white medical tape was reported to ISDH on 03/18/11. The employee the allegation was made against should have bee immediately suspended, even though it was immediately investigated by management s at the time the allegation was voiced. There was no evidence of any tape used. 2. OTHERS IDENTIFIED: There were no others identified. 3. SYSTEMS IN PLACE:a. Ar in-service was held on 2/07/11 and 2/08/11 for all staff to educ on current policies and procedures for allegations of abuse. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff the requirements according to Policy/Procedure for Abuse,	on e sing on of at as en e e e e e e e e e e e e e e e e e e	03/18/2011

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155319	B. WIN			03/16/2011
			B. 11111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				1TH ST	
WATERS	OF CLINTON THE			1	DN, IN47842	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	<u> </u>	DATE
		of Resident B had not			including: 1) protecting the resident by	
	been reported to	Indiana Department of			having a staff member remain	
	Health (ISDH).				with the resident,	
					2) protecting the resident by	
	2. Review of "Co	ompliment and Concern			immediately suspending	
		3/11, completed by staff			whomever the allegation has	
	·	ted an allegation of			been made against	
	*	release seat belt was			immediately reporting to/notifying the	
		n white medical tape on			Administrator/Designee	
	3/13/11 by RN #2	_			4) intiating the investigation,	
	3/13/11 UY KIN #.	۷.			and	
		200			5) reporting to other officials in	n
		ninistrator on 3/16/11 at			accordance with State law	
	-	eated she was notified on			through established procedure	
	3/13/11 of allega	tion of Resident A's self			(including to the State Survey Certification Agency).	and
	release seat belt v	was taped together with			4. MONITORING:a. The	
	medical tape by l	RN #2. The			Administrator/Director of Nursi	ina
	Administrator in	dicated RN #2 was not			will review/audit, daily QA	
	suspended after a	allegation and completed			stand-up meetings, any	
	-	/11. The Administrator			allegations of abuse, as and if	
		N #2 worked 3/14/11.			any occur, to ensure proper	
		or also indicated the			policies and procedures and a immediate steps are properly	"
					conducted to ensure the safety	v of
	anegation had no	ot been reported to ISDH.			the residents. This will be an	,
					on-going QA process.	
	_	was cited on 2/7/11. The				
		implement a systemic			B. The Administrator/Designe	
	plan of correction	n to prevent recurrence.			will review all allegations of ab	
					with the Medical Director in the quarterly QA meeting.	=
	This Federal tag	relates to Complaint			quarterly QA meeting.	
	IN00084624.	•			5. This plan of correction	
					constitutes our credible	
	3.1-28(c)				allegation of compliance with	ո
	3.1-28(d)				all regulatory requirements.	
	3.1 - 20(u)				DATE COMPLETE: 3/18/11.	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/16/2011	
	PROVIDER OR SUPPLIER		STREET A 375 S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		UNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155319	A. BUILD B. WING	ING		03/16/2	011
	PROVIDER OR SUPPLIER			375 S 1	ADDRESS, CITY, STATE, ZIP CODE 1TH ST DN, IN47842		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID	<u> </u>		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P.	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	F022	TAG	DEFICIENCY)		DATE
F0225 SS=D	ALGOLLII ONI ON		F022		F 225 Investigate/Report Allegations/Individuals It is the intent of this facility to ensure all alleged violations or physical abuse and/or misappropriation of resident property are immediately report to ISDH; and further potential abuse is prevented until investigation is completed by immediate suspension of persallegation is against. 1. CORRECTIVE ACTION:a. The allegation of Resident B's missimoney was reported to ISDH 03/16/11. b. The allegation taping Resident A's release seedlt with white medical tape wereported to ISDH on 03/18/11. The employee the allegation of made against should have been immediately suspended, even though it was immediately investigated by management at the time the allegation was voiced. There was no evidence of any tape used. 2. OTHERS IDENTIFIED: The were no others identified. 3. SYSTEMS IN PLACE:a. A in-service was held on 2/07/11 and 2/08/11 for all staff to edu on current policies and procedures for allegations of abuse. b. Directed In-Service Trainin will be conducted 3/29/11 and 3/30/11 to educate facility staff the requirements according to Policy/Presedure for Abuse.	orted son e sing on of eat eas eas en staff ce re n 1 cate	03/18/2011
					i olicy/i locedule fol Abuse,		
					Policy/Procedure for Abuse,	-	
					!		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/16/2011	
	ROVIDER OR SUPPLIER		B. WING GS/16/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
				including: 1) protecting the resident by having a staff member remai with the resident, 2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials accordance with State law through established procedu (including to the State Survey Certification Agency). 4. MONITORING:a. The Administrator/Director of Nur will review/audit, daily QA stand-up meetings, any allegations of abuse, as and any occur, to ensure proper policies and procedures and immediate steps are properly conducted to ensure the safe the residents. This will be an on-going QA process. B. The Administrator/Design will review all allegations of a with the Medical Director in the quarterly QA meeting. 5. This plan of correction constitutes our credible allegation of compliance will all regulatory requirements. DATE COMPLETE: 3/18/11.	in res y and sing if all y ety of ee abuse he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	A. BUII B. WIN	LDING		COMPL 03/16/2	ETED
		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIE	R			ITH ST		
WATERS OF CLINTON THE	<u> </u>		CLINTO	ON, IN47842		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	TE	(X5) COMPLETION DATE
	LISC IDENTIFTING INFORMATION)	F02		<u> </u>		
F0225 SS=D		F02	25	F 225 Investigate/Report Allegations/Individuals It is the intent of this facility to ensure all alleged violations or physical abuse and/or misappropriation of resident property are immediately report to ISDH; and further potential abuse is prevented until investigation is completed by immediate suspension of persallegation is against. 1. CORRECTIVE ACTION:a. The allegation of Resident B's mismoney was reported to ISDH 03/16/11. b. The allegation taping Resident A's release seed belt with white medical tape wereported to ISDH on 03/18/11. The employee the allegation wade against should have been immediately suspended, even though it was immediately investigated by management at the time the allegation was voiced. There was no evidence of any tape used. 2. OTHERS IDENTIFIED: The were no others identified. 3. SYSTEMS IN PLACE:a. A in-service was held on 2/07/12 and 2/08/11 for all staff to edu on current policies and procedures for allegations of abuse. b. Directed In-Service Training will be conducted 3/29/11 and 3/30/11 to educate facility staff the requirements according to Policy/Procedure for Abuse,	orted son e sing on of eat eas vas en staff ce re n 1 cate	03/18/2011

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SUF COMPLET	
		155319	A. BUILI			03/16/201	
			B. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		375 S 11TH ST				
	OF CLINTON THE		CLINTON, IN47842				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	l P	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re C	OMPLETION DATE
					including: 1) protecting the resident by having a staff member remain with the resident, 2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation, and 5) reporting to other officials in accordance with State law through established procedure (including to the State Survey Certification Agency). 4. MONITORING:a. The Administrator/Director of Nursiwill review/audit, daily QA stand-up meetings, any allegations of abuse, as and if any occur, to ensure proper policies and procedures and a immediate steps are properly conducted to ensure the safet the residents. This will be an on-going QA process. B. The Administrator/Designe will review all allegations of abwith the Medical Director in the quarterly QA meeting. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. DATE COMPLETE: 3/18/11.	n es and ing II y of e	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MU A. BUII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2011	
		155519	B. WIN			03/10/2	011
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF CLINTON THE				11TH ST DN, IN47842		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226		review and interview, the	F02	26	F 226 Develop/Implement		03/18/2011
SS=D	facility failed to	implement written			Abuse/Neglect, ETC Policies It is the intent of this facility to		
	policies and proc	cedures for abuse of			implement written policies and		
	residents and mis	sappropriation of resident			procedures for abuse of residents	and	
	property for 2 of	f 4 residents with			misappropriation of resident prop		
	allegations of ph	ysical abuse and/or			with allegations of physical abuse	e	
		in a sample of 12; in			and/or missing property to		
	that 1.) the allega	* ′			immediately report to the ISDH a	ınd	
	, ,	orted to other officials			prevent further potential abuse	at	
) further potential abuse			during investigations including no allowing staff to work.	οι	
		ed during investigations			anowing start to work.		
	_				1. CORRECTIVE ACTION:		
		gations were allowed to			a. The allegation of Resident B's	3	
		legations were voiced by			missing money was reported to IS	SDH	
	staff. (Residents	A and B).			on 3/16/11.		
	Findings include	: ssing Property Report			b. The allegation of taping Resid A's release seat belt with white medical tape was reported to ISD		
		3/16/11 at 1 p.m.,			on 3/18/11.		
		nt B had identified the			2. OTHERS IDENTIFIED:		
		3/12/11 and had notified			There were no others identified.		
	_						
	_	of the missing money			3. SYSTEMS IN PLACE:		
	_	ngs on 3/12/11. The			a. This facility performed inservi		
	•	the resident stated the			on 2/07/11 and 2/08/11 to all staf	f in	
	_	sing out of her drawer			the building.		
		and $3/12/11$. The report			b. <u>Directed In-Service Training</u>	a	
		ney had been replaced by			will be conducted 3/29/11 and	_	
	the facility on 3/	14/11.			3/30/11 to educate facility staff		
					the requirements according to	the	
	Interview of the	Administrator on 3/16/11			Policy/Procedure for Abuse,		
	at 12:10 p.m., inc	dicated the allegation of			including: 1) protecting the resident by		
	_	of resident property i.e.			having a staff member remain		
		of Resident B had not			with the resident,		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING		COMPLETED
		155319	B. WIN			03/16/2011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				1TH ST	
WATERS	OF CLINTON THE			1	DN, IN47842	
			_		<u> </u>	1 (75)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
IAG			+	IAG	2) protecting the resident by	DATE
	1 ^	Indiana Department of			immediately suspending	
	Health (ISDH).				whomever the allegation has	
					been made against	
		ompliment and Concern			3) immediately reporting	
	Form," dated 3/1	3/11, completed by staff			to/notifying the	
	person #1 indicat	ted an allegation of			Administrator/Designee 4) intiating the investigation,	
	Resident A's self	release seat belt was			and	
	taped closed with	white medical tape on			5) reporting to other officials in	n
	3/13/11 by RN #2	2.			accordance with State law	
					through established procedure	• • • • • • • • • • • • • • • • • • •
	Interview of Adn	ninistrator on 3/16/11 at			(including to the State Survey Certification Agency).	and
	12:45 p.m., indic	ated she was notified on			4. MONITORING:	
	_	tion of Resident A's self			a. The Administrator/Director	of
		was taped together with			Nursing will review/audit, daily	I
	medical tape by l				stand-up meetings, any	
	1	dicated RN #2 was not			allegations of abuse, as and if	
					any occur, to ensure proper policies and procedures and a	,
	_	allegation and completed (11. The Administrator			immediate steps are properly	"
					conducted to ensure the safety	y of
		N #2 worked 3/14/11.			the residents. This will be an	
		or also indicated the			on-going QA process.	
	allegation had no	t been reported to ISDH.			D. The Administrator/Designs	
					B. The Administrator/Designe will review all allegations of ab	
		cility's current policy and			with the Medical Director in the	I
	1 ^	'Abuse-Response to			quarterly QA meeting.	
		d 6/1/10, on 3/16/11 at 3				
	p.m., indicated ".	Procedures2. If the			5. This plan of correction	
	allegation is relat	ted to physical, verbal, or			constitutes our credible allegation	• • • • • • • • • • • • • • • • • • •
	mental abuse of a	a resident, the			of compliance with all regulator requirements. DATE	y
	Administrator, d	esignee, or staff member			COMPLETE: 3/18/11.	
		e of the allegation will				
	_	teps to prevent further				
		while the investigation is				
	1 ^	I on the circumstances,				
	F 32222. 23300					
					ļ	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/16/2011			
100019		B. WING						
NAME OF PROVIDER OR SUPPLIER WATERS OF CLINTON THE			STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842					
				l .	, III - 7 0 - 2			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VIE.	DATE	
	staff-resident, seg	: immediate separation of paration of residents,						
	suspension of sta	* * * *						
	implementation of	of one-on-one						
	observation of th	e resident(s) and other						
	actions as deeme	d appropriate by the staff						
	member in attend	dance. 3. The						
	Administrator or	designee shall gather as						
	much information	n as possible to						
	determine wheth	er there is reasonable						
	cause to believe	an event has occurred. If						
	reasonable cause	exists to believe an						
	event occurred, t	he Administrator is						
	responsible to re	port to the Indiana State						
	Department of H	ealth as per reporting						
	-	e Administrator or						
	designee will not	tify the resident's						
	_	and any State or Federal						
	•	ations per the Indiana						
	_	t of Health Reporting						
	_	the suspected perpetrator						
		f the facility, he/she will						
		suspended until the						
	_	been completed or						
	_	ordance with employee						
	policies"	r in the result of						
	1							
	Review of the fac	cility's current policy and						
		'Reportable Unusual						
	_	ated 6/1/10 on 3/16/11 at						
	3 p.m., indicated							
	-	e reported: Facilities are						
	required by law t	-						
	required by law t	o report unusuur						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING D. WING 03/16/201			ETED		
100010			B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/10/2	011
NAME OF PROVIDER OR SUPPLIER				375 S 1			
	OF CLINTON THE			CLINTO	N, IN47842		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	DATE
		in 24 hours of occurrence					
		Care Division. CFR					
	_	tes that 'the facility must					
	ensure that all all	leged violations involving					
		glect, or abuse, including					
	injuries of unkno						
		of resident property are					
	1 -	ately to the administrator					
		d to other officials in					
		State law through					
	_	edures (including State					
	Survey and Ceru	fication Agency)'. "					
	This deficiency v	was cited on 2/7/11. The					
	· ·	implement a systemic					
	l -	n to prevent recurrence.					
	This Federal tag rela IN00084624.	ates to Complaint					
	3.1-28(a)						

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING COMP			COMPL	ETED
155319		B. WIN			03/16/2	U11	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
WATERS OF CLINTON THE			375 S 11TH ST CLINTON, IN47842				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	E02	TAG			DATE 02/19/2011
F0226 SS=D			F02	26	F 226 Develop/Implement Abuse/Neglect, ETC Policies It is the intent of this facility to implement written policies and procedures for abuse of residents misappropriation of resident proposition of physical abuse and/or missing property to immediately report to the ISDH aprevent further potential abuse during investigations including nallowing staff to work. 1. CORRECTIVE ACTION: a. The allegation of Resident B's missing money was reported to Ison 3/16/11. b. The allegation of taping Resident A's release seat belt with white medical tape was reported to ISD on 3/18/11. 2. OTHERS IDENTIFIED: There were no others identified. 3. SYSTEMS IN PLACE:	e and ot SDH	03/18/2011
					a. This facility performed inserv on 2/07/11 and 2/08/11 to all staf the building.	f in	
					b. <u>Directed In-Service Trainin</u> will be conducted 3/29/11 and 3/30/11 to educate facility staf the requirements according to Policy/Procedure for Abuse, including: 1) protecting the resident by having a staff member remain with the resident,	f on the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2011			
NAME OF PROVIDER OR SUPPLIER WATERS OF CLINTON THE			B. WING OS/16/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	CLINTO ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) 2) protecting the resident by immediately suspending whomever the allegation has been made against 3) immediately reporting to/notifying the Administrator/Designee 4) intiating the investigation and 5) reporting to other officials accordance with State law through established procedu (including to the State Surve Certification Agency). 4. MONITORING: a. The Administrator/Director Nursing will review/audit, da stand-up meetings, any allegations of abuse, as and any occur, to ensure proper policies and procedures and immediate steps are properly conducted to ensure the safe the residents. This will be an on-going QA process. B. The Administrator/Design will review all allegations of a with the Medical Director in the quarterly QA meeting. 5. This plan of correction constitutes our credible allegations of compliance with all regulater requirements. DATE COMPLETE: 3/18/11.	COMPLETION DATE So in tres by and tres by		

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING COMP			COMPL	ETED
155319		B. WIN			03/16/2	U11	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
WATERS OF CLINTON THE			375 S 11TH ST CLINTON, IN47842				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		(X2) MULTIPLE CO A. BUILDING	UNSTRUCTION	COMPLETED 03/16/2011			
		B. WING					
NAME OF PROVIDER OR SUPPLIER WATERS OF CLINTON THE			STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN47842				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
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